SERFF Tracking Number:	*AENX-G128324039*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR053360100002*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*2011 HCR- Appeals-External Review (ALIC IVL Direct*		
Project Name/Number:	*2011 HCR- Appeals-External Review (ALIC IVL Direct)/AR053360100002*		

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2011 HCR- Appeals-External Review (ALIC IVL Direct	SERFF Tr Num: AENX-G128324039	State: Arkansas
TOI: H16I Individual Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)	Co Tr Num: AR053360100002	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: SPI AetnaSPI	Disposition Date: 05/02/2012
	Date Submitted: 05/02/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 2011 HCR- Appeals-External Review (ALIC IVL Direct)	Status of Filing in Domicile:
Project Number: AR053360100002	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 05/02/2012
	State Status Changed: 05/02/2012
Deemer Date:	Created By: SPI AetnaSPI
Submitted By: SPI AetnaSPI	Corresponding Filing Tracking Number:

PPACA: Grandfathered Immed Mkt Reforms
PPACA Notes: null
Healthcare.gov ID:
Filing Description:

The purpose of this submission is to revise Aetna's appeals and external review provisions in response to the "Amendment to the Interim Final Rule" issued collectively by the Department of Labor, the Department of the Treasury and the Department of Health and Human Services, and published in the Federal Register on June 24, 2011. More specifically, the revisions reflected in the attached form concern the following:

- The time period for urgent care claim determinations changing from 24 hours to 72 hours. We are filing these amounts in ranges in the event of future changes to the regulations.
- Clarifying that there are certain exceptions to the exhaustion of process provision that do not result in the member having been considered to have exhausted the appeals process and therefore eligible for external review.
- Expanding the external review language to indicate that claims involving medical judgment may be eligible for external review.

State Narrative:

Company and Contact

Filing Contact Information

Nhu Nguyen, Product & Regulatory Approvals Consultant
151 Farmington Avenue
Mail Stop RW61
Hartford, CT 06156
860-273-7546 [Phone]
860-952-2069 [FAX]

Filing Company Information

Aetna Life Insurance Company	CoCode: 60054	State of Domicile: Connecticut
151 Farmington Avenue	Group Code: 1	Company Type:
Hartford, CT 06156	Group Name: Aetna	State ID Number:
(860) 273-7546 ext. [Phone]	FEIN Number: 06-6033492	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	$50.00	05/02/2012	58847206

SERFF Tracking Number:	*AENX-G128324039*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/02/2012	05/02/2012

SERFF Tracking Number:	*AENX-G128324039*	*State:*	*Arkansas*
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Project Name/Number:	*2011 HCR- Appeals-External Review (ALIC IVL Direct)/AR053360100002*		

Disposition

Disposition Date: 05/02/2012
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AENX-G128324039*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	HCR IVL Direct CovLtr	Approved-Closed	Yes
Supporting Document	EOV Policy Amendment	Approved-Closed	Yes
Form	Appeals-ER Policy Amendment	Approved-Closed	Yes

SERFF Tracking Number:	*AENX-G128324039*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	
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Product Name:	*2011 HCR- Appeals-External Review (ALIC IVL Direct*		
Project Name/Number:	*2011 HCR- Appeals-External Review (ALIC IVL Direct)/AR053360100002*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/02/2012	GR-IVLAppealsER-Pol 03	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Appeals-ER Policy Amendment	Initial		0.000	AL GE AIVLAppealsERPol 03.PDF

Aetna Life Insurance Company

Hartford, Connecticut 06156

Policy Amendment - ***Appeals Procedure and External Review***

[Policyholder: Mr. John Doe]

[Policy No.: XXXX]

Effective Date: This Policy Amendment is effective on [January 1, 2010] [the later of:

January 1, 2010; or
The date you become covered under the Policy].

[The policy noted above has been amended.] The following summarizes the changes in the policy and it is amended accordingly. This amendment is effective on the date(s) shown above.

The following Appeals Procedure [Exhaustion of Process,] [and External Review] provisions [are added to] [replace the same provisions appearing in] your Policy [or any amendment or rider issued to you]:

Appeals Procedure

Definitions

Adverse Benefit Determination (Decision): A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- [Coverage determinations, including] plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

[As to medical and **prescription drug** claims,] An **adverse benefit determination** also means the termination of a covered person's coverage back to the original effective date (rescission) as it applies under any rescission provision appearing in the Policy.

Appeal: An [oral or] written request to **Aetna** to reconsider an **adverse benefit determination**.

[**Complaint**: Any [oral or] written expression of dissatisfaction about quality of care or the operation of the Plan.]

Concurrent Care Claim Extension: A request to extend a course of treatment that was previously approved.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a course of treatment that was previously approved.

External Review: A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by [the State Insurance Commissioner] [Aetna or the U.S. Office of Personnel Management, as determined by Aetna] and made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the appeals process.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- seriously jeopardize your life or health;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Comment [MDC1]: Non-material clean up item per Marta Collins 1/31/2012.

Full and Fair Review of Claim Determinations and Appeals

[As to medical and **prescription drug** claims and **appeals** only,] **Aetna** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

Claim Determinations – Health Coverage

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. [As to medical and **prescription drug** claims only,] if **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a concurrent care claim, to your **provider**.

Urgent Care Claims

Aetna will notify you of an **urgent care** claim decision as soon as possible, but not later than [24-72] hours after the claim is made.

If more information is needed to make an **urgent care claim** decision, **Aetna** will notify the claimant within [24-72] hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier to occur:

- the receipt of the additional information; or
- the end of the 48 hour period given the **physician** to provide **Aetna** with the information.

Pre-Service Claims

Aetna will notify you of a **pre-service** claim decision as soon as possible, but not later than 15 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 15 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Post-Service Claims

Aetna will notify you of a **post-service** claim decision as soon as possible, but not later than 30 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, **Aetna** will notify you of a claim decision for **urgent care** as soon as possible but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

Concurrent Care Claim Reduction or Termination

Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

[As to medical and **prescription drug** claims only,] if you file an **appeal**, coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

[Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about an [**network**] **provider** you must [call or] write Member Services. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.]

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one level [or two levels (Level Two only applies to dental, vision and hearing claims)] of **appeal**. [As to medical and **prescription drug** claims only,] a **final adverse benefit determination** notice may also provide an option to request an **External Review** *(if available)***.**

You have 180 calendar days with respect to Health Claims following the receipt of notice of an **adverse benefit determination** to request your Level One **appeal**. Your **appeal** [may be submitted orally or] [must be submitted] in writing and must include:

- Your name.
- [The Policyholder's name.]
- A copy of **Aetna's** notice of an **adverse benefit determination**.
- Your reasons for making the **appeal**.
- Any other information you would like to have considered.

[Send your written **appeal** to Member Services at the address shown on your ID Card, or call in your **appeal** to Member Services using the telephone number shown on your ID Card.]

[Send your written **appeal** to the address shown on the notice of **adverse benefit determination**, or you may call in your **appeal** using the telephone number listed on the notice.]

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to **Aetna**.

[As to medical and **prescription drug** claims only, you may be allowed to provide evidence or testimony during the appeal process in accordance with the guidelines established by the Federal Department of Health and Human Services.]

Appeal – Medical and Prescription Drug Claims

A review of an **Appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 72 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

Post-Service Claims
Aetna shall issue a decision within 60 calendar days of receipt of the request for an Appeal.

[Level One Appeal –Dental, Vision and Hearing Claims

A review of a [Level One] **Appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an Appeal.]

[Level Two Appeal - Dental, Vision and Hearing Claims

A Level Two Appeal applies only to dental, vision and hearing claims. If **Aetna** upholds an **adverse benefit determination** at the first level of **appeal**, and the reason for the decision was based on **medical necessity** or **experimental or investigational** reasons, you or your authorized representative have the right to file a Level Two **appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of a decision of a Level One **Appeal**.

A review of a Level Two **appeal** of an **adverse benefit determination** of an **urgent care claim, a Pre-Service Claim, or a Post-Service Claim** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 36 hours of receipt of the request for a Level Two **Appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 15 calendar days of receipt of the request for a Level Two **Appeal**.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for a Level Two **Appeal**.]

[Exhaustion of Process

You must exhaust the applicable Level One [and Level Two] processes of the Appeal Procedure before you:

- Contact the [insert state name] Department of Insurance to request an investigation of a [**complaint** or] **appeal**; or
- File a complaint or **appeal** with the [insert state name] Department of Insurance; or
- Establish any:

    litigation;

    arbitration; or

    administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.]

[As to medical and **prescription drug** claims only,] under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.]

Important Note:

[As to medical and **prescription drug** claims only,] if **Aetna** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or an **appeal** straight to an **External Review**. Your claim or internal **appeal** *will not* go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna**.

[External Review

[As to medical and **prescription drug** claims only,] you may receive an **adverse benefit determination** or **final adverse benefit determination** [because **Aetna** determines that:
- the claim involves medical judgment;
- the care is not **necessary** or appropriate;
- a service, supply or treatment is **experimental or investigational** in nature.]

In these situations, you may request an **External Review** if you or your provider disagrees with **Aetna's** decision.

To request an **External Review**, [any of] the following requirements must be met:
- You have received an **adverse benefit determination** notice by **Aetna,** and **Aetna** did not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services.
- You have received a **final adverse benefit determination** notice [of the denial of a claim] by **Aetna**.
- [Your claim was denied because **Aetna** determined that the care was not **necessary** or appropriate or was **experimental or investigational**.]
- You qualify for a faster review as explained below.
- [As to dental, vision and hearing claims only, the cost of the initial service, supply or treatment in question for which you are responsible exceeds [$100-$500].]

The notice of **adverse benefit determination** or **final adverse benefit determination** that you receive from **Aetna** will describe the process to follow if you wish to pursue an **External Review**, and include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to the U.S. Office of Personnel Management within 123 calendar days of the date you received the **adverse benefit determination** or **final adverse benefit determination** notice. You also must include a copy of the notice and all other pertinent information that supports your request.

The U.S. Office of Personnel Management will contact the ERO that will conduct the review of your claim. The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the *Request for External Review Form*, and will follow **Aetna's** contractual documents and plan criteria governing the benefits. You will be notified of the decision of the ERO usually within 45 calendar days of **Aetna's** receipt of your request form and all the necessary information.

A faster review is possible if your **physician** certifies (by telephone or on a separate *Request for External Review Form*) that a delay in receiving the service would:
- seriously jeopardize your life or health; or
- jeopardize your ability to regain maximum function; or
- if the **adverse benefit determination** relates to **experimental or investigational** treatment, if the **physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.]

[You may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay;** or health service for which you received **emergency care**, but have not been discharged from a facility.

Faster reviews are decided within 72 hours after **Aetna** receives the request.

Aetna will abide by the decision of the ERO, except where **Aetna** can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to **Aetna**. **Aetna** is responsible for the cost of sending this information to the ERO and for the cost of the external review [except for dental, vision and hearing claims].

For more information about the Appeals Procedure or **External Review** processes, call the Member Services telephone number shown on your ID card.]

This amendment makes no other changes to the Policy.

[

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

[Amendment: XXXX]
[Issue Date: October 1, 20XX]

SERFF Tracking Number:	*AENX-G128324039*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR053360100002*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*2011 HCR- Appeals-External Review (ALIC IVL Direct*		
Project Name/Number:	*2011 HCR- Appeals-External Review (ALIC IVL Direct)/AR053360100002*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/02/2012
Comments:			
Attachment:			
AR_Idv direct_Read Cert.PDF			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	05/02/2012
Bypass Reason:	n/a		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	05/02/2012
Bypass Reason:	n/a		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	05/02/2012
Bypass Reason:	n/a		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	05/02/2012
Comments:			
Attachment:			

SERFF Tracking Number:	*AENX-G128324039*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	
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AR IvlDirect PPACA Summary.PDF

		Item Status:	Status Date:
Satisfied - Item:	HCR IVL Direct CovLtr	Approved-Closed	05/02/2012

Comments:

Attachment:

AR_INV direct_ Appeals-Resc CovLtr.PDF

		Item Status:	Status Date:
Satisfied - Item:	EOV Policy Amendment	Approved-Closed	05/02/2012

Comments:

Attachment:

AL GE EAIVLAppealsERPol 03.PDF

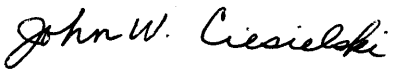
STATE OF ARKANSAS

CERTIFICATE OF READABILITY

Aetna Life Insurance Company NAIC 60054

This is to certify that the form (s) referenced below has/have achieved a Flesh Reading Ease Score as indicated below listed below and comply with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258 cited as the Life and Disability Insurance Policy Language Simplification Act.

FORM NUMBER	**SCORE**
GR-IVLAppealsER-Pol 03	50.1

Signature:  Date: May 2, 2012

Name: John W Ciesielski

Title: Product and Regulatory Approvals Senior Consultant

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☒ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☐ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Aetna Life Insurance Company	001-60054	AENX-G128324039	GR-11741-HCR	☐ Yes ☒ No

PPACA Uniform Compliance Summary

SECTION A ñ Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16I-Individual Health	**Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19**	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☐ **Yes** ☒ No If **no,** please explain.
	Explanation: Plans are compliant			
	Page Number:			
H16I-Individual Health	**Eliminate Annual Dollar Limits on Essential Benefits** Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☒ No If **no,** please explain.
	Explanation: Plans are compliant			
	Page Number:			
H16I-Individual Health	**Eliminate Lifetime Dollar Limits on Essential Benefits**	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no,** please explain.	☐ **Yes** ☒ No If **no,** please explain.
	Explanation: Plans are compliant			
	Page Number:			
H16I-Individual Health	**Prohibit Rescissions –** Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☒ No If **no,** please explain.	☐ **Yes** ☒ No If **no,** please explain.
	Explanation: Plans are compliant			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A ñ Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16I-Individual Health	**Preventive Services –** Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☒ No If **no,** please explain.
	Explanation: Plans are compliant			
	Page Number:			
H16I-Individual Health	**Extends Dependent Coverage for Children Until age 26 –** If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no,** please explain.	☐ **Yes** ☒ No If **no,** please explain.
	Explanation: Plans are compliant			
	Page Number:			
H16I-Individual Health	**Appeals Process –** Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☒ **Yes** ☐ No If **no,** please explain.
	Explanation: Amendment			
	Page Number: GR-IVLAppealsER-Pol 03			
H16I-Individual Health	**Emergency Services –** Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☒ No If **no,** please explain.
	Explanation: Plans are compliant			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A ñ Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16I-Individual Health	**Access to Pediatricians** – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☒ No If **no,** please explain.
	Explanation: Plans are compliant			
	Page Number:			
H16I-Individual Health	**Access to OB/GYNs** – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☒ No If **no,** please explain.
	Explanation: Plans are compliant			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B ñ Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no,** please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no,** please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no,** please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no,** please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B ñ Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** • ☐ No If **no,** please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			

• For plan years beginning before January 1, 2010, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B ñ Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			

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May 2, 2012

Insurance Commissioner Jay Bradford
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: Aetna Life Insurance Company
Form #: GR-IVLAppealsER-Pol 03

Dear Commissioner Bradford:

The Individual Policy forms referenced above are being submitted for your Department's review and approval on a general use basis. These forms are new and do not replace any previously filed forms. They are in final format rather than being drafts or proofs.

The purpose of this submission is to revise Aetna's appeals and external review provisions in response to the "Amendment to the Interim Final Rule" issued collectively by the Department of Labor, the Department of the Treasury and the Department of Health and Human Services, and published in the Federal Register on June 24, 2011. More specifically, the revisions reflected in the attached form concern the following:

- The time period for urgent care claim determinations changing from 24 hours to 72 hours. We are filing these amounts in ranges in the event of future changes to the regulations.
- Clarifying that there are certain exceptions to the exhaustion of process provision that do not result in the member having been considered to have exhausted the appeals process and therefore eligible for external review.
- Expanding the external review language to indicate that claims involving medical judgment may be eligible for external review.

The policy amendments will be used in conjunction with the Individual Policy approved by your Department on 11/8/2007.

The enclosed amendment will be used for both "grandfathered" and "non-grandfathered" plans. It is important to note that, although the appeals and external review reform applies only to non-grandfathered plans, Aetna is applying this requirement to both grandfathered and non-grandfathered plans to establish consistency for all health plans.

PPACA Uniform Compliance Summary

As required by your state, please find attached a completed PPACA Uniform Compliance Summary. The "*Section A. Individual Health Benefit Plans."* portion of the Summary has been completed for this submission.

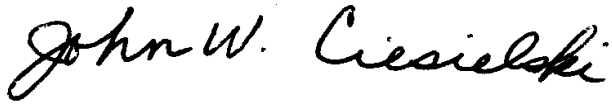
The enclosed amendment form will be issued to existing and future policyholders to amend their forms in response to health care reform.

Variability, as indicated by bracketed material on the forms, is required so that only the appropriate language may be reflected on the forms. Upon issuance, the placement of textual material may vary to avoid gaps that would otherwise be created by the deletion of bracketed material. Provisions may appear in sequence other than that shown. Connective words and phrases, which serve the grammatical purpose of meaningful continuity and do not affect the description of the payment of benefits or other terms or conditions of the group policy, may vary as the sense demands. Detailed Explanations of Variable Material have been included.

There is no rate impact with regard to the information provided on this form.

We request approval of the enclosed forms and any attachments

We trust that you will find everything in order, and we look forward to your response. If you have any questions regarding this submission, please do not hesitate to contact me at the above mailing address, telephone number or e-mail address.



John W Ciesielski
Senior Consultant
Product & Regulatory Approvals

Aetna Life Insurance Company
Appeals and External Review

Explanation of Variability
Policy Amendment Form GR-IVLAppealsER-Pol 03

General Comments

- Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected based upon the plan of benefits.
- *Although the appeals and external review reform applies only to non-grandfathered plans, Aetna is applying this requirement to both grandfathered and non-grandfathered plans to establish consistency for all health plans.*
- This amendment is intended to be issued to new and existing policyholders.
- Upon issue, this amendment form will be customized in accordance with a policyholder's plan of benefits, the specific forms issued to a policyholder, state mandates and this explanation of variability.
- The placement of the text within the form may vary to avoid gaps that would otherwise be created by the deletion of bracketed text.
- Any reference to "policyholder" may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning used in a policyholder's forms.
- The page numbers at the bottom of the form will change as needed.
- The name and signature of the Aetna officer at the end of the amendment will change to the most current information.
- If applicable, the Amendment Designation and Issue Date will be inserted at the end of the amendment. These fields are reserved for Aetna's use to allow for the electronic assembly information regarding a Policyholder's specific documents.
- The bracketed designation [00000] at the bottom right corner is a field reserved for Aetna's use to allow for the addition of a drafting system code that assists with the electronic assembly of Policyholder specific documents. Upon issue of this form, the bracketed term [State] will be omitted if the page has not been modified due to state mandates. If the page has been modified, then the postal abbreviation of your state may be added to identify that the form is state specific.

Policy Amendment Form GR-IVLAppealsER-Pol 03

1. The "Policyholder Name" and "Policy Number" field is for policyholder-specific information and may not print upon issue. The bracketed phrase "[The policy noted above has been changed.]" will print if the policy number is included on the amendment upon issue.
2. The lead-in paragraphs will be revised to accurately state the manner in which the provisions will amend the insurance forms of a policyholder. The references to Exhaustion of Process and External Review will print if applicable under a policyholder's plan.
3. *Definition - Adverse Benefit Determination*: In the second bullet, the words "coverage determinations, including" will be included when the external review process is triggered by the broader coverage determination standard as required by PPACA regulations.
   The rescission paragraph will always print when the Policyholder's plan includes multiple lines of coverage and the medical and prescription drug lines of coverage is subject to the requirements of PPACA regulations. Aetna may extend the appeals and external review process in the event of rescission to other lines of coverage. When this occurs, the bracketed phrase "As to medical and prescription drug claims only," will be omitted if it applies to all other coverage under a policyholder's plan or it will be expanded to specifically identify the other lines of coverage to which this provision applies.

4. *Definition - Appeal*: An appeal must be requested in writing but may also be requested orally.
5. *Definition - Complaint:*
   a. The definition of “complaint” may or may not be incorporated into the provision, depending on whether or not a complaint component is included in a policyholder's plan.
   b. Any complaint must be expressed in writing but may also be permitted orally.
6. *Full and Fair Review of Claim Determinations and Appeals:* This section may be expanded to include dental, vision or hearing claims.
7. *Claim Determinations - Health Coverage:*
   a. Written notice of an adverse benefit determination may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as standalone dental, vision and hearing.
   b. Concurrent Care Claim Reduction or Termination-This continuation provision may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as standalone dental, vision and hearing. In accordance with the final HHS regulation, it may be duplicated under other parts of the Appeal process.
   c. The "hour" limitations in the Urgent Care Claims section are bracketed in the event they need to be revised in accordance with future PPACA or state regulations.
8. *Complaints*:
   a. This provision may be included in a policyholder's plan.
   b. The term "network" may be revised to "in-network”, “participating”, “preferred” or some other term of similar meaning as used within a policyholder's forms.
   c. The complaint must be expressed in writing but may also be permitted orally.
9. *Appeals of Adverse Benefit Determinations:*
   a. The reference to "Level Two" will print in accordance with a policyholder's plan.
   b. The external review process may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as dental, vision and hearing.
   c. The plan may require that the appeal be made in writing.
   d. The Policyholder's name may be required information for the appeal.
   e. The appeal process may allow that a member submit a written or oral appeal. When the plan requires a written appeal, the references to "calling in an appeal" will be omitted. The address may appear on the back of the ID card or in the notice of adverse benefit determination. Only one of these two options will print.
   f. Evidence/Testimony-This provision is bracketed because it will be omitted if the policyholder's plan does not include medical or prescription drug coverage. For medical and prescription drug coverage, it will be included as required and in accordance with the final HHS regulation. It may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as dental, vision and hearing. In accordance with the final HHS regulation, it may be duplicated under other parts of the Appeal process.

10. *Level One Appeal - Dental, Vision and Hearing Claims*
    a. This appeal process description will print if included as part of the policyholder's plan. The reference to "Level One" will be omitted if there is only one level of appeal.
    b. If the Dental, Vision and Hearing Appeals Procedure includes only <u>One Level</u>, then the following appeal time periods will apply:
        - Urgent Care Claims will be made in 72 hours;
        - Pre-Service Claims will be made in 30 calendar days; and
        - Post-Service Claims will be made in 60 calendar days.
11. *Level Two Appeal - Dental, Vision and Hearing Claims:* This Level Two appeal process description will print if included as part of the policyholder's plan.
12. *Exhaustion of Process:*
    a. This provision is subject to inclusion or omission based upon a policyholder's plan.
    b. The reference to "Level Two" will print if applicable to the policyholder's plan.
    c. The reference to [complaint or] will be included when the Appeals Procedure includes the Complaint provision.
    d. The last paragraph applies to medical and prescription drug expenses only. It may be expanded to include dental, vision or hearing expenses.
    e. Important Note Box: This Important Note Box applies to medical and prescription drug claims only. It may be expanded to include dental, vision or hearing coverage.
13. *External Review:*
    a. This provision may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as standalone dental, vision and hearing. The entire provision may be omitted if a policyholder's plan only includes standalone dental, vision or hearing coverage.
    b. When external review is triggered by a claim denial due to a determination that the care is not medically necessary or appropriate or is experimental or investigational then:
        - The language in the first paragraph beginning with “because Aetna determines that…” will print.
        - In the second bulleted item of the third paragraph, the optional language “of the denial of a claim” will print.
        - The third bulleted item of the third paragraph will print.
    c. When external review is triggered by the broader coverage determination standard as required by PPACA regulations, the three items mentioned above will not print, and the words “any of” will print in the first sentence of the third paragraph.
    d. If external review applies to dental, vision and hearing expenses under a policyholder's plan, the "cost of the service, supply or treatment" may be limited to a dollar amount and will vary within the stated range.
    e. Aetna may incur the entire cost of the External Review for dental, vision and hearing claims *(see the third to the last paragraph).*